Nebraska Center for the Education of Children who are Blind or Visually Impaired

824 10th Avenue; PO Box 129
Nebraska City, NE 68410
(402) 873-5513 or (800) 826-4355
FAX (402) 873-3463
www.ncecbvi.org

REQUEST FOR SERVICES

Outreach Department

Please indicate your request below. Once this form is received, you will be contacted about specific details which will further assist NCECBVI with the service requested.

Return this form to the Outreach Director, by email: thilligoss@esu4.net or by U.S. mail:
NCECBVI, Attention: Tanya Hilligoss, 824 10th Avenue, P.O. Box 129, Nebraska City, NE, 68410.

Service requested:

Psychological Evaluation: Intellectual, Academic, Social/Emotional/Behavioral, Developmental
Please attach the following: Current MDT, IEP, Most Recent Psychological Report, Most Recent Eye Doctor Report(s), Other Pertinent Medical/Health Information

Mentoring for TVI

Professional Development

Transition Consultation

PLEASE LIST SPECIFIC INFORMATION ABOUT YOUR REQUEST:

Name of Person Requesting Services:
This is the person we will contact for additional information.

Position:

Preferred Phone (+Area Code):

Office Phone Cell Phone

Email:

Mailing Address (Street/P.O. Box, City, Zip):

Name of Teacher of the Visually Impaired:

Preferred Phone (+Area Code):

Office Phone Cell Phone

Name of Person to Send Invoice To:

Position:

Preferred Phone (+Area Code):

Office Phone Cell Phone

Email:

Mailing Address (Street/P.O. Box, City, Zip):

Signature of Person Authorizing Services: **Date:**

Financial Agreement: The undersigned person, as a representative of the school district, authorizes services and agrees the school district is financially responsible for all charges incurred for services rendered by the Nebraska Center for the Education of Children who are Blind or Visually Impaired in accordance with the rates approved by the Nebraska Department of Education for the current school year. It is understood that all costs are considered allowable for special education reimbursement purposes.

Complete this page ***ONLY IF REQUESTING PSYCHOLOGICAL EVALUATION OR TRANSITION CONSULTATION***

Student Name:

Date of Birth: Age: Gender: Grade:

School District:

School District Address (Street/P.O. Box, City, Zip):

Parent/Guardian Name(s):

Parent/Guardian Address (Street/P.O. Box, City, Zip):

Following the evaluation or consultation, a report will be emailed to the person making the request for this service and the teacher of the visually impaired serving the student. If there are additional staff members who should receive a copy of the report, please indicate below:

Name:

Position:

Email:

Name:

Position:

Email:

Complete this page *ONLY IF REQUESTING*
PSYCHOLOGICAL EVALUATION OR TRANSITION CONSULTATION

PARENTAL CONSENT

I have received a copy of the notice of this proposed evaluation or consultation, understand the content of this notice and **give consent** for the evaluation specified in this notice. I understand this consent is voluntary and may be revoked at any time.

I **give consent** for photographs and videos to be taken of my child during assessments performed by NCECBVI to facilitate appropriate educational assessments and program planning.

Signature of Parent/Guardian: Date:

Parents of children with a disability have protection under the procedural safeguards of the Individuals with Disabilities Education Act (IDEA). A copy of these "Parental Rights in Special Education" can be obtained from the following website: www.education.ne.gov. You should read this information carefully and if you have any questions regarding your rights, you may contact Sally Schreiner, NCECBVI Campus Administrator, at 402-873-5513 or 800-826-4355. You may contact any of the following resources to help you understand the federal and state laws for educating children with disabilities and parental rights granted by those laws. An explanation of your rights will be provided at no cost by any of the Nebraska Department of Education Regional Offices: Lincoln (402-471-2471), Omaha (402-595-2177), Educational Service Unit 4 (402-274-4354).

PERMISSION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, Parent/Guardian of ,

give my permission to release the following information concerning this child:

Psychological Information

Educational Information

Medical Information

Other:

Signature of Parent/Guardian: Date:

revised 11/16/16